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ABSTRACT

This article reviews the literature concerning the use of seclusion in psychiatric treatment facilities during the last 15 years. Following a brief historical summary of how seclusive techniques have been used in psychiatric treatment, recent literature is presented on: (1) demographic and statistical data; (2) theoretical justifications; (3) possible abuse and misuse; and (4) staff and patient perceptions of seclusion in psychiatric care. State mental health codes are examined with respect to policies governing the use of seclusion, including which mental health professionals may order seclusion, the length of time patients may be secluded, and under what clinical circumstances a patient may be secluded. (Author)

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Seclusion: The Unwanted and Undiscussed Child of Mental Health Care

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Introduction

Probably no technique has been practiced as frequently but discussed as infrequently as the seclusion and isolation of psychiatric patients. Wells (1972) documents that seclusive techniques date all the way back to early Greek history. Although recent advances in psychotherapy and psychopharmocology have virtually eliminated the need for the mechanical and physical restraint of psychiatric patients, seclusion has remained a commonly used method of treating mentally ill, hospitalized patients (Plutchik, Karasu, Conte, Siegel and Jarret, 1978). Numerous mental health professionals have documented the intolerable and inhumane abuses of seclusion and isolation in psychiatric care (Greenblatt, York and Brown, 1955), but these abuses took place most frequently in an era when psychiatric care was primarily custodial. The purpose of this article has been to review current thinking on the use of seclusion in psychiatric treatment through a review of the literature on the use of seclusion over the last 15 years.

Current psychiatric literature was examined in an effort to accurately assess attitudes toward the use of seclusion and seclusive techniques in psychiatric care. The existing recent literature was divided into the following content areas for the purpose of this review: (1) Demographic and statistical studies, (2) Theoretical justifications, (3) Possible abuse and misuse of seclusion, and (4) Staff and patient perceptions of the use of seclusion.

Demographic and Statistical Studies

Several studies have attempted to provide demographic and statistical data on the use of seclusion in hospitals. These studies have examined seclusion in relation to diagnostic categories, the behavioral precipitants most often leading to seclusion, and the number of patients who are placed in seclusion compared with the total number of patients admitted.

Regarding the relationship between seclusion and diagnostic categories, most studies indicate the schizophrenic and manic patients are more likely to be secluded than are patients in other diagnostic categories. Binder (1979) found paranoid schizophrenics were more likely to be secluded than patients in any other diagnostic category. She also found that depressed patients were not as likely to be secluded. Both Wells (1972) and Mattson and Sacks (1978) found schizophrenic and hypomanic patients to be the most frequently secluded patient groups, while Plutchik et al. (1978) found schizophrenics to be the most frequently secluded patient group. Soloff (1978), who studied the use of physical restraint rather than seclusion, found that patients who were diagnosed as psychotic were more likely to be restrained than were non-psychotic patients.

Various studies have examined the precipitating reasons for the use of seclusion in hospital settings. Most commonly, these behavioral precipitants are determined by retrospectively examining the nursing notes for secluded patients. Binder (1979) listed the four most common reasons for seclusion as being agitation, uncooperativeness, anger, and a history of violence. Mattson and Sacks (1978) list the five most common precipitants of seclusion as assaultive to others, threatening

or verbally abusive, destructive to property, dangerous to self, and behavior disruptive to the therapeutic environment. This latter category was the most frequently mentioned reason, and included such things as slamming doors, running up and down corridors, and persistent screaming. Plutchik et al. (1978) found that the most commonly mentioned justifications for seclusion were agitated and uncontrolled behavior, physical aggression toward other patients, loud and noisy behavior, and physical aggression toward staff. Soloff (1978), studying restraint rather than seclusion, found that violation of community and administrative standards (not violent or abusive behaviors) was the most frequently cited reason for the physical restraint of patients.

Concerning the percentage of patients who are actually secluded, the highest percentage was that given by Binder (1979), who noted that 44% of all patients admitted to her short-term, crisis evaluation unit were secluded at one time or another. Plutchik et al. (1978), examining the percentage of patients secluded in a large, municipal hospital designed for short-term care, found that 26% (from a pool of 450 consecutive admissions) were secluded. Mattson and Sacks (1978) found that 7.2% of all patients in a private psychiatric hospital were secluded during a calendar year. Wells (1972) found that approximately 4% of patients on an inpatient unit of a large, teaching hospital were secluded over a year long period. Soloff (1978) found that 3.6% of all patients admitted to a large, military teaching hospital were physically restrained. He did not present any data on the frequency of the use of seclusion.

Theoretical Justifications for Seclusion

Some authors view the use of seclusion as unnecessary, unwarranted, and unjustified as a treatment in psychiatric care. Pilette (1978) mentions that the use of seclusion has somehow managed to avoid the scrutiny of the mental health profession. She believes that most reasons and justifications for the use of seclusion have really been based upon the desire for tranquillity and docility among patients. Suga (1967) describes the elimination of the use of restraint and seclusion in a psychiatric hospital by "administrative order." He also details some of the problems associated with this rather abrupt way of eliminating seclusion - primarily in terms of the resistances that are encountered with the direct care staff, most of whom had become quite accustomed to using restraint and seclusion to deal with difficult situations. Stern (1970), although apparently not arguing for the complete abolition of seclusion, does state that the very existence of seclusion or isolation rooms constitutes a statement of what staff members expect in terms of patient behavior. He also mentions that the use of seclusion may actually reinforce the kinds of behaviors that the staff is trying to eliminate. In a study dealing with the elimination of physical restraint techniques in a large mental hospital in New York, Jacoby, Babikian, McLamb, and Hohlbein (1958) describe the many beneficial after effects they consider to have occurred as a result of the elimination of any techniques of physical restraint. They do not say whether isolation and seclusion, in addition to restraint, were also eliminated from their facility.

Most authors, however, do not make a blanket condemnation of seclusion. Advocates of the use of seclusion in psychiatric treatment offer various reasons to justify its use. These justifications usually center around the needs of the individual patient, but occasionally reference is made to the fact that seclusion room use may be of benefit to other patients, as well as staff members. Fitzgerald and Long (1973) see the basic reasons for seclusion as: (1) it is a means of decreasing overwhelming environmental stimulation for the patient, (2) seclusion provides protection to the patient from harming himself/herself or others, (3) seclusion prevents a patient from destroying his/her or others' property, and (4) it provides an opportunity to develop trusting relationships. This latter reason is not explained in any further detail. Gutheil (1978) and Kilgalen (1977) both state essentially the same justifications for seclusion, although they use different terminology. Gutheil speaks about the need for containment (keeping the patient from personal harm or harm to others), isolation (giving the patient a relief from interpersonal conflicts), and a decrease in sensory input. Kilgalen says that seclusion is needed for the external control of the combative patient, to protect the patient from self-injury, and to reduce stimuli for excited patients. And finally, Plutchik et al. (1978) state that they feel that the main reason for the use of seclusion is that it provides the patient an opportunity to complete acting out and to then reconstitute ego defenses. In only one article in the literature was there a relatively sophisticated, indepth attempt to explain the therapeutic benefits of seclusion on theoretical grounds.

This is done in the research reported by Plutchik et al. (1978). In this article the authors use two "models" to explain seclusion, an ethological model and a more behavioristic, "time-out" model. Their basic premise in an ethological explanation of seclusion is the fact that in any society (an inpatient psychiatric unit thus can be viewed as a mini-society), it is occasionally necessary to isolate certain members from the rest of the society for the good of the society. Viewing seclusion room usage in more behavioristic terms, it can be understood as an attempt to provide a temporary suspension of the possibility of a patient's receiving positive reinforcement for nondesirable behavior. If, therefore, a patient is assaulting another patient, seclusion provides a "time-out" from the attention that the aggressive patient might receive from the staff and other patients for this inappropriate behavior.

Abuse and Misuse of Seclusion

Even those professionals supportive of the use of seclusion in psychiatric treatment recognize that seclusive techniques can be abused or misused. In addition, many recognize that negative consequences can follow from the use of seclusion room, sometimes even coinciding with positive effects. Binder (1979) was concerned that her data on the use of seclusion room in an inpatient crisis intervention unit might have indicated that staff use of seclusion was sometimes a weapon of retaliation. Kilgalen (1977) although supportive of the use of seclusion in many situations, felt that it was definitely contraindicated for suicidal patients.

Four articles deal in more depth with the possible detrimental effects of seclusion on patient care. Gutheil (1978) generally felt that seclusion represented a safe and effective manner of therapeutic intervention. However, he did mention that seclusion could cause the following as far as patients' perceptions and feelings are concerned: (1) seclusion envy, i.e., other patients may feel that a secluded patient is being "favored" by the staff, (2) lasting anathema, i.e., the use of seclusion may be a factor in causing a patient to develop a continued antagonism toward mental health treatment, and (3) a profound sense of abandonment. Mattson and Sacks (1978) discussed the complications following the use of seclusion by studying various demographic and diagnostic variables for patients placed in seclusion during a calendar year. They found that the patient's therapist provided much less documentation of the patient's total care and that seclusion often seemed to worsen patients' self-abusive or assaultive behaviors. They also found that the direct care staff tended to see seclusion as a treatment in and of itself, i.e., they thought that seclusion treated the basic cause of a patient's disorder. Plutchik et al. (1978) conducted three separate studies concerning the use of seclusion in a large, university affiliated, municipal hospital. They believed that two major problems in the use of seclusion were the arbitrary bases for its use by the staff and the lack of clearcut criteria to determine what length of time a patient should stay in seclusion. Finally, in one of the more interesting articles in the literature, Wadeson and Carpenter (1976) examined the implications of the seclusion room experience for hospitalized patients. The

patients were hospitalized on a research unit of the National Institute of Mental Health (NIMH). The patients were all psychotic but no antipsychotic drugs were used in their treatment. Patients were all asked to complete drawings concerning their feelings about their hospitalization two to three weeks after admission, two to three weeks prior to discharge, and one year after discharge. Interestingly, a high percentage of the patients spontaneously drew pictures related to their experience of seclusion. In interpreting the results of the study, the authors suggested that seclusion room techniques: (1) may have intensified paranoid tendencies in certain patients, (2) certainly may have been a factor in the bitterness many patients felt about their hospitalization, even a year after discharge, and (3) often intensified the hallucinatory experiences of floridly psychotic patients.

Patient and Staff Perceptions of Seclusion

Interestingly, few researchers have investigated patient and staff perceptions of seclusion. While various authors have alluded to the fact that direct care staff aides often are resistant to any professional who suggests that patient behaviors commonly resulting in seclusion can and should be dealt with in other ways (Jacoby, et al., 1958; Suga, 1967), few researchers have made systematic efforts to examine staff attitudes. One exception is the work done by Plutchik et al. (1978). In this study, attitudes among the nursing staff, the direct care staff, and the professional staff were compared concerning the use of seclusion. Generally, all three of these groups felt that seclusion was beneficial in modifying

patients' undesirable behaviors and helping patients to regain emotional and behavioral control. The nursing staff felt that seclusion benefited the individual patient the most, while the direct care staff and professional staff felt that the ward (milieu) benefited the most. It was also noteworthy that professionals experienced considerably more "guilt" about putting patients in seclusion than either the nursing or direct care staff. In examining patient attitudes, Plutchik and his associates interviewed 30 patients who had been on an inpatient ward at least 2 weeks and had been secluded at least once. They found that patient perceptions of the kinds of behaviors for which they could be placed in seclusion coincided with staff views. A majority of patients retrospectively said that they felt that seclusion benefited them, but close to 40% felt that it did not help them at all.

Wadeson and Carpenter (1976) rather incidently found out what patients' perceptions of the seclusion room experience were. They worked with acutely schizophrenic patients hospitalized on a NIMH clinical research unit. Because psychotropic medications were used sparingly or not at all during investigative periods, seclusion was used frequently for severe management problems. As part of the research protocol, patients were asked to draw pictures concerning their feelings about hospitalization. Each patient was asked to draw a "free" (self-chosen) picture, a self-portrait, a picture of his/her psychiatric illness, a picture of any hallucination experienced, and a picture of any delusion experienced. Thus, although no patient was directly asked to draw a picture about his/her perception of seclusion, over one-third spontaneously did. In evaluating the content of these "seclusion"

drawings, Wadeson and Carpenter found that the content fell into four major categories: (1) hallucinatory experiences (usually perceived as pleasurable), (2) delusional experiences, which were consistently displeasurable to the patient, e.g., the patients' drawings in this area usually had themes concerning the use of seclusion as a punishment for a crime committed, with seclusion being viewed often as a jail or gas chamber, (3) intense affect, usually negative, e.g., seclusion being seen as the ultimate in abandonment and hopelessness by the patient, and (4) attending staff members, i.e., drawings which dealt with the person sitting outside the secluded patient's room. In general, the authors felt that the use of seclusion may have an overall negative effect on the treatment of their patient population.

State Mental Health Code Policies Concerning Seclusion

Finally, an attempt was made to compare the foregoing clinical criteria for seclusion given in the psychiatric literature with the criteria for the use of seclusion according to state mental health codes. Letters requesting information concerning state policy concerning the use of seclusion in mental health facilities were sent to the state departments of mental health in all 50 states. If a state did not respond to this initial request, two follow-up letters were sent. If the information received still was not sufficient, a direct phone call was made to the department of mental health. Even given this rather extensive procedure, 8 states still had not provided sufficient information. Thus, the following information is based on an examination of the policies of existing state mental health codes

concerning the use of seclusion in 42 states. The information received was organized to examine the following: (1) The rationale and justifications given in mental health codes for the use of seclusion, (2) Which mental health professionals may order the use of seclusion for patients, and (3) Safeguards put upon the use of seclusion to insure patient protection.

Table 1 details the justification for the use of seclusion according to the mental health codes in 42 states. The number of states mentioning the criteria is given in parentheses (see Table 1).

Regarding who may order seclusion for patients, almost all states delegate ultimate responsibility for the use of seclusion to the physician. In only one state (Colorado) could another professional (licensed psychologist) order seclusion without needing final approval from a physician. Most states, however, have provisions that allow for physician approval to be made post facto. That is, other mental health professionals may authorize the use of seclusion for a particular patient, and the authorization from the physician does not have to be obtained until later (usually within 1 to 4 hours). In some states direct care staff (i.e., psychiatric aides) may even utilize seclusion on an emergency basis without direct professional authorization. Again, however, they are required to obtain professional approval within a certain time period. Parenthetically, it might be noted that mental health codes often differ concerning patient care standards according to whether a particular facility is psychiatric or developmental (developmental referring to a facility primarily concerned with the care of mentally retarded individuals). From a brief examination

of how state standards differ, it appears that developmental facilities have more rigid standards as to how long residents may be secluded (some states not even allowing the use of seclusion at all with mentally retarded residents), while generally allowing greater latitude as to who may initially authorize seclusion.

Finally, most state mental health codes specify safeguards to be observed when patients are placed in seclusion. Most states specify how long an initial order for seclusion can be, as well as how long subsequent orders can specify that patients remain in seclusion. States vary in this regard, some states specifying that initial orders can be for no longer than 1 hour, while other states allow initial orders of up to 24 hours. State codes also usually specify how often a patient in seclusion is to be checked and observed, some states specifying as frequently as every 5 minutes, while other states allowing only once per hour observation. The majority of state mental health codes also delineate the time limits and guidelines for such patient needs as toileting, fluid and food intake, and bathing.

Discussion

One is struck by the paucity of articles on seclusion in the psychiatric literature over the last fifteen years. As might have been suspected before the review was begun, seclusion seems to be an "unwanted and undiscussed child" of mental health care, i.e., everyone concerned with mental health care knows it exists but few want to talk about it. It is encouraging to note, however, that most of the articles reviewed in this paper have come out in the last five years. Perhaps

this indicates more willingness on the part of mental health professionals to speak about an aspect of psychiatric care that many would see as an inhumane relic of past centuries.

Regarding the rationale for the use of seclusion in psychiatric care, most justifications center around the reasons that are also given to justify commitment of patients to hospitals: protection from harm to self or others. Fitzgerald and Long (1973) do give a substantively different reason for seclusion, namely that it provides an opportunity to develop trusting relationships, but they do not explain this concept in much detail. Plutchik et al., (1978) rather than attempting to justify seclusion on clinical grounds, take a more sociological perspective on the use of seclusion in their study of inpatient care. Finally, although not the focus of this article, seclusion and social isolation are also techniques commonly used in child and adolescent mental health care. Frequently, writers in this area use rationale other than protection from harm to self or others to explain why the feel seclusion is beneficial in the treatment of children and adolescents (Endres and Goke, 1973).

Although many authors discuss the clinical indications for the use of seclusion, relatively little attention is given as to when seclusion is contraindicated. Kilgalen (1977) did mention that she felt seclusion was definitely contraindicated for suicidal patients. It is also interesting to note that even though the prototypical rationale for seclusion is protection from harm to self or others, Mattson and Sacks (1978) found data that indicated that use of seclusion actually worsened patients' self-abusive or assaultive behaviors.

One is also struck by the fact that very little research has been done on the use of seclusion. Although authors state that the frequency of seclusion has decreased in their facility over the years (Wells, 1972), this observation is usually based on anecdotal reports rather than actual data. One would also think that a fruitful area of research would be studies examining the attitudes of mental health professionals toward seclusion. A good start was made in the study done by Plutchik et al. (1978). They also examined patient perceptions of the seclusion experience, as did Wadeson and Carpenter (1976), although their findings were actually more incidental than experimental.

Finally, a few comments can be made about existing state mental code policies concerning the use of seclusion. Almost all the state codes mention that "potential harm to self or others" is the primary justification for secluding patients. When it is not mentioned specifically in a state code, one could probably assume that it is implied in the (more global) justification that is given (eg., to meet the medical needs of the patient, to provide effective treatment, to help reach therapeutic goals, etc.). It is also interesting to note that only 4 states mention "destructive to property" as a justification for seclusion. Only 4 states allow seclusion as a part of a behavior modification program. Two (2) states mention that seclusion may be used to "encourage patients in the active participation of their recovery," which sounds like a euphemistic rationale for a "shape up or ship out" approach to patient care.

It is also informative that many of the justifications and indications for seclusion mentioned in the psychiatric literature are mentioned infrequently if at all in the state mental health codes. Binder (1979), Fitzgerald and Long (1973), Gutheil (1978), and Kilgalen (1977), all mention that seclusion is justified as a means of decreasing sensory input and environmental stimulation, although only one (1) state specifically allowed this circumstance as an indication for seclusion. Binder (1979) also mentioned "uncooperativeness" and "anger," Plutchik et al. (1978) mentioned "loud and noisy behavior," and Fitzgerald and Long (1973) mentioned "an opportunity to develop trusting relationships" as reasons that seclusion was used in psychiatric care. These reasons do not appear to be justified according to existing state mental health codes. That seclusion usage in psychiatric care does not always coincide with state policy would probably not come as a surprise to many mental health professionals.

It is hoped that this review of the use of seclusion in modern psychiatric care has provided information that will serve as an impetus and a prod to further research and discussion in this often ignored and undiscussed area.

References

Barton, W. E. Administration in psychiatry. Springfield, Illinois: Charles C. Thomas, 1962, 129.

Binder, R. L. The use of seclusion on an inpatient crisis intervention unit. Hospital and Community Psychiatry, 1979, 30 (4), 266 - 269.

Bursten, B. Using mechanical restraints on acutely disturbed psychiatric patients. Hospital and Community Psychiatry, 1976, 26, 757 - 759.

Caudhill, W. The psychiatric hospital as a small society. Cambridge, Massachusetts: Harvard University Press, 1958.

Conolly, J. Treatment of the insane without mechanical restraints. London: Smith, Elder, & Co., 1856.

Endres, V. J., and Goke, D. H. Time-out rooms in residential treatment centers. Child Welfare, 1973, 52, 359 - 366.

Evenson, R., Sletten, I., Altman, H., and Brown, M. Disturbing behavior: A study of incident reports. Psychiatry Quarterly, 1974, 48, 266 - 275.

Fitzgerald, R. G., and Long, I. Seclusion in the management of severely disturbed manic and depressed patients. Perspectives in Psychiatric Care, 1973, 11 (2), 59 - 64.

Friedman, H.J. Some problems of inpatient management with borderline patients. American Journal of Psychiatry, 1969, 126, 299 - 304.

Greenblatt, M., York, R. H., and Brown, E.L. From custodial to therapeutic patient care in mental hospitals. New York: Russell Sage Foundation, 1955.

Gutheil, T.C. Observations on the theoretical basis for seclusion of the psychiatric inpatient. American Journal of Psychiatry, 1978, 135 (3), 325 - 328.

Jacoby, M. G., Babikian, H., McLamb, E., and Hoklbein, B. A study in non-restraint. American Journal of Psychiatry, 1958, 115, 114 - 120.

Kilgalen, R. K. The effective use of seclusion. Journal of Psychiatric Nursing and Mental Health Services, 1977, January, 22 - 25.

Kraepelin, E. One hundred years of psychiatry. New York: Philosophical Library, 1962.

Lion, J. R. Evaluation and management of the violent patient. Springfield, Illinois: Charles C. Thomas, 1972.

Mattson, M. R., and Sacks, M. H. Seclusion: Uses and complications. American Journal of Psychiatry, 1978, 135 (10), 1210 - 1213.

Mendel, W., and Green, G. The therapeutic management of psychological illness. New York: Basic Books, Inc., 1967.

Pilette, P. C. The tyranny of seclusion: A brief essay. Journal of Psychiatric Nursing and Mental Health Services, 1978, October, 19 - 21.

Plutchik, R., Karasu, T. B., Conte, H.R., Siegel, B., and Jarret, I. Toward a rationale for the seclusion process. The Journal of Nervous and Mental Disease, 1978, 166 (8), 571 - 579.

Reusch, J. Psychiatric care. New York: Grune & Stratton, 1964.

Soloff, P. H. Behavioral precipitants of restraint in the modern milieu. Comprehensive Psychiatry, 1978, 19(2), 179 - 183.

Stern, R. Standard operating procedures and institutionalization on the psychiatric unit. American Journal of Orthopsychiatry, 1970, 40, 744 - 750.

Suga, B. Seclusion? Journal of Psychiatric Nursing, 1967, 5 (4), 328.

Van Eerden, W. E. Stages of adjustment to the seclusion room in adolescence. Unpublished manuscript, Pine Rest Christian Hospital, Grand Rapids, Michigan, 1975.

Voetberg, J. The use of seclusion as a treatment method for the omnipotent adolescent. Unpublished manuscript, Pine Rest Christian Hospital, Grand Rapids, Michigan, 1975.

Wadeson, H., and Carpenter, W. T. Impact of the seclusion room experience. The Journal of Nervous and Mental Disease, 1976, 163 (5), 318 - 328.

Weitzel, W. J., and Medrano, P.P. Use of isolation as a therapeutic technique. Unpublished manuscript, Donald M. Whaley Children's Center, Flint, Michigan, 1977.

Wells, D. A. The use of seclusion on a university hospital psychiatric floor. Archives of General Psychiatry, 1972, 26, 410 - 413.

Table 1

Criteria and Justifications for the Use of Seclusion

Potential or actual harm to self or others (34)

To provide effective treatment, to help reach therapeutic goals, etc. (6)

To meet the medical needs of the patient (5)

As part of a behavior modification program (4)

Substantial property damage (4)

To encourage patients in the active participation of their recovery (2)

Following an attempted suicide (2)

To set limits (2)

Danger of imminent elopement (2)

Help client gain self-control (1)

Decrease level of stimulation when patient is in a state of hyperactivity (1)

If the physician views it as potentially beneficial to the patient (1)

NOTE: The numbers in parentheses indicate the number of states whose mental health codes mention the above criteria and justifications. The data are based on information received from 42 states.